House Bill 2117

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SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Creates Healthy Kids Plan, which includes private health option to provide affordable, accessible health care to children. Imposes duties on Department of Human Services and Office of Private Health Partnerships to carry out plan.

Requires prepaid managed care health services organization to reimburse community health center or safety net clinic for services provided by center or clinic to enrollee of organization.

Establishes Private Health Option Program Account. Continuously appropriates moneys in account to Office of Private Health Partnerships for purposes of administering private health option.

Establishes Healthy Kids Plan Fund. Continuously appropriates moneys in fund to Department of Human Services for purposes of Healthy Kids Plan.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to health; creating new provisions; amending ORS 414.025, 414.725, 414.839, 735.701 and 735.710; appropriating money; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. Sections 2 and 3 of this 2009 Act are added to and made a part of ORS chapter 414.

SECTION 2. (1) The Healthy Kids Plan is created to provide affordable, accessible health care for Oregon's children. The plan is composed of:

(a) Medical assistance administered by the Department of Human Services under the state programs funded by Title XIX of the Social Security Act, under the State Children's Health Insurance Program funded by Title XXI of the Social Security Act and under state programs funded by the Legislative Assembly; and

(b) A private health option administered by the Office of Private Health Partnerships under sections 9, 10, 11 and 12 of this 2009 Act.

(2) A child or a person authorized to act on behalf of a child may apply to the department for a determination of the child's eligibility for the Healthy Kids Plan.

(3) When an application is received by the department under subsection (2) of this section, the department shall determine whether the child is eligible for medical assistance. If an eligible child's family income is at or below 200 percent of the federal poverty guidelines, the department shall enroll the child in the appropriate medical assistance program referred to in subsection (1)(a) of this section.

(4) If the department determines that a child for whom application has been made under subsection (2) of this section is not eligible for medical assistance but is eligible for enrollment in the private health option described in section 10 of this 2009 Act, the department shall transfer the application to the office to complete the enrollment process.

(5) The department shall adopt rules for annually renewing enrollment in the Healthy

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

Kids Plan.

(6) The department and the office shall streamline and simplify the application process for the Healthy Kids Plan, by means including the development and implementation of an online application process for the plan.

SECTION 3. (1) A child is eligible for enrollment in the Healthy Kids Plan only if the income of the child's family is at or below 200 percent of the federal poverty guidelines.

(2)(a) The Department of Human Services may by rule require a period of uninsurance prior to enrollment.

(b) The department may adopt rules specifying exceptions to any period of uninsurance required pursuant to paragraph (a) of this subsection.

(c) As used in this subsection, "period of uninsurance" means a time during which a person is not enrolled in an unsubsidized or privately funded health benefit plan.

(3) The department may not impose an asset requirement for enrollment in the Healthy Kids Plan.

SECTION 4. Section 3 of this 2009 Act is amended to read:

Sec. 3. (1) A child is eligible for enrollment in the Healthy Kids Plan only if the income of the child's family is at or below [*200*] **300** percent of the federal poverty guidelines.

(2)(a) The Department of Human Services may by rule require a period of uninsurance prior to enrollment.

(b) The department may adopt rules specifying exceptions to any period of uninsurance required pursuant to paragraph (a) of this subsection.

(c) As used in this subsection, "period of uninsurance" means a time during which a person is not enrolled in an unsubsidized or privately funded health benefit plan.

(3) Notwithstanding subsection (1) of this section, a child whose family's income is above 300 percent of the federal poverty guidelines shall be offered the opportunity to purchase a private insurance product offered through the Health Kids Plan.

[*(3)*] **(4)** The department may not impose an asset requirement for enrollment in the Healthy Kids Plan.

SECTION 5. ORS 414.025, as amended by section 18a, chapter 861, Oregon Laws 2007, is amended to read:

414.025. As used in this chapter, unless the context or a specially applicable statutory definition requires otherwise:

(1) "Category of aid" means assistance provided by the Oregon Supplemental Income Program, aid granted under ORS 412.001 to 412.069 and 418.647 or federal Supplemental Security Income payments.

(2) "Categorically needy" means, insofar as funds are available for the category, a person who is a resident of this state and who:

(a) Is receiving a category of aid.

(b) Would be eligible for, but is not receiving a category of aid.

(c) Is in a medical facility and, if the person left such facility, would be eligible for a category of aid.

(d) Is under the age of 21 years and would be a dependent child as defined in ORS 412.001 except for age and regular attendance in school or in a course of professional or technical training.

(e)(A) Is a caretaker relative, as defined in ORS 412.001, who cares for a child who would be a dependent child except for age and regular attendance in school or in a course of professional or

technical training; or

(B) Is the spouse of the caretaker relative.

(f) Is under the age of 21 years, is in a foster family home or licensed child-caring agency or institution under a purchase of care agreement and is one for whom a public agency of this state is assuming financial responsibility, in whole or in part.

(g) Is a spouse of an individual receiving a category of aid and who is living with the recipient of a category of aid, whose needs and income are taken into account in determining the cash needs of the recipient of a category of aid, and who is determined by the Department of Human Services to be essential to the well-being of the recipient of a category of aid.

(h) Is a caretaker relative as defined in ORS 412.001 who cares for a dependent child receiving aid granted under ORS 412.001 to 412.069 and 418.647 or is the spouse of the caretaker relative.

(i) Is under the age of 21 years, is in a youth care center and is one for whom a public agency of this state is assuming financial responsibility, in whole or in part.

(j) Is under the age of 21 years and is in an intermediate care facility which includes institutions for persons with mental retardation; or is under the age of 22 years and is in a psychiatric hospital.

(k) Is under the age of 21 years and is in an independent living situation with all or part of the maintenance cost paid by the Department of Human Services.

(L) Is a member of a family that received aid in the preceding month under ORS 412.006 or 412.014 and became ineligible for aid due to increased hours of or increased income from employment. As long as the member of the family is employed, such families will continue to be eligible for medical assistance for a period of at least six calendar months beginning with the month in which such family became ineligible for assistance due to increased hours of employment or increased earnings.

(m) Is an adopted person under 21 years of age for whom a public agency is assuming financial responsibility in whole or in part.

(n) Is an individual or is a member of a group who is required by federal law to be included in the state's medical assistance program in order for that program to qualify for federal funds.

(o) Is an individual or member of a group who, subject to the rules of the department and within available funds, may optionally be included in the state's medical assistance program under federal law and regulations concerning the availability of federal funds for the expenses of that individual or group.

(p) Is a pregnant woman who would be eligible for aid granted under ORS 412.001 to 412.069 and 418.647, whether or not the woman is eligible for cash assistance.

(q) Except as otherwise provided in this section and to the extent of available funds, is a pregnant woman or child for whom federal financial participation is available under Title XIX of the federal Social Security Act.

(r) Is not otherwise categorically needy and is not eligible for care under Title XVIII of the federal Social Security Act or is not a full-time student in a post-secondary education program as defined by the Department of Human Services by rule, but whose family income is less than the federal poverty level and whose family investments and savings equal less than the investments and savings limit established by the department by rule.

(s) Would be eligible for a category of aid but for the receipt of qualified long term care insurance benefits under a policy or certificate issued on or after January 1, 2010. As used in this paragraph, "qualified long term care insurance" means a policy or certificate of insurance as defined in ORS 743.652 (6).

(3) "Child" means a person under 19 years of age.

(4) "Health benefit plan" has the meaning given that term in ORS 735.720.

[*(3)*] **(5)** "Income" has the meaning given that term in ORS 411.704.

[*(4)*] **(6)** "Investments and savings" means cash, securities as defined in ORS 59.015, negotiable instruments as defined in ORS 73.0104 and such similar investments or savings as the Department of Human Services may establish by rule that are available to the applicant or recipient to contribute toward meeting the needs of the applicant or recipient.

[*(5)*] **(7)** "Medical assistance" means so much of the following medical and remedial care and services as may be prescribed by the Department of Human Services according to the standards established pursuant to ORS 414.065, including payments made for services provided under an insurance or other contractual arrangement and money paid directly to the recipient for the purchase of medical care:

(a) Inpatient hospital services, other than services in an institution for mental diseases;

(b) Outpatient hospital services;

(c) Other laboratory and X-ray services;

(d) Skilled nursing facility services, other than services in an institution for mental diseases;

(e) Physicians' services, whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere;

(f) Medical care, or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law;

(g) Home health care services;

(h) Private duty nursing services;

(i) Clinic services;

(j) Dental services;

(k) Physical therapy and related services;

(L) Prescribed drugs, including those dispensed and administered as provided under ORS chapter 689;

(m) Dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(n) Other diagnostic, screening, preventive and rehabilitative services;

(o) Inpatient hospital services, skilled nursing facility services and intermediate care facility services for individuals 65 years of age or over in an institution for mental diseases;

(p) Any other medical care, and any other type of remedial care recognized under state law;

(q) Periodic screening and diagnosis of individuals under the age of 21 years to ascertain their physical or mental impairments, and such health care, treatment and other measures to correct or ameliorate impairments and chronic conditions discovered thereby;

(r) Inpatient hospital services for individuals under 22 years of age in an institution for mental diseases; and

(s) Hospice services.

[*(6)*] **(8)** "Medical assistance" includes any care or services for any individual who is a patient in a medical institution or any care or services for any individual who has attained 65 years of age or is under 22 years of age, and who is a patient in a private or public institution for mental diseases. "Medical assistance" includes "health services" as defined in ORS 414.705. "Medical assistance" does not include care or services for an inmate in a nonmedical public institution.

[*(7)*] **(9)** "Medically needy" means a person who is a resident of this state and who is considered

eligible under federal law for medically needy assistance.

[*(8)*] **(10)** "Resources" has the meaning given that term in ORS 411.704. For eligibility purposes, "resources" does not include charitable contributions raised by a community to assist with medical expenses.

SECTION 6. ORS 414.725 is amended to read:

414.725. (1)(a) Pursuant to rules adopted by the Department of Human Services, the department shall execute prepaid managed care health services contracts for health services funded by the Legislative Assembly. The contract must require that all services are provided to the extent and scope of the Health Services Commission's report for each service provided under the contract. The contracts are not subject to ORS chapters 279A and 279B, except ORS 279A.250 to 279A.290 and 279B.235. Notwithstanding ORS 414.720 (8), the rules adopted by the department shall establish timelines for executing the contracts described in this paragraph.

(b) It is the intent of ORS 414.705 to 414.750 that the state use, to the greatest extent possible, prepaid managed care health services organizations to provide physical health, dental, mental health and chemical dependency services under ORS 414.705 to 414.750.

(c) The department shall solicit qualified providers or plans to be reimbursed for providing the covered services. The contracts may be with hospitals and medical organizations, health maintenance organizations, managed health care plans and any other qualified public or private prepaid managed care health services organization. The department may not discriminate against any contractors that offer services within their providers' lawful scopes of practice.

(d) The department shall establish annual financial reporting requirements for prepaid managed care health services organizations. The department shall prescribe a reporting procedure that elicits sufficiently detailed information for the department to assess the financial condition of each prepaid managed care health services organization and that includes information on the three highest executive salary and benefit packages of each prepaid managed care health services organization.

(e) The department shall require compliance with the provisions of paragraph (d) of this subsection as a condition of entering into a contract with a prepaid managed care health services organization.

(2) The department may institute a fee-for-service case management system or a fee-for-service payment system for the same physical health, dental, mental health or chemical dependency services provided under the health services contracts for persons eligible for health services under ORS 414.705 to 414.750 in designated areas of the state in which a prepaid managed care health services organization is not able to assign an enrollee to a person or entity that is primarily responsible for coordinating the physical health, dental, mental health or chemical dependency services provided to the enrollee. In addition, the department may make other special arrangements as necessary to increase the interest of providers in participation in the state's managed care system, including but not limited to the provision of stop-loss insurance for providers wishing to limit the amount of risk they wish to underwrite.

(3) As provided in subsections (1) and (2) of this section, the aggregate expenditures by the department for health services provided pursuant to ORS 414.705 to 414.750 may not exceed the total dollars appropriated for health services under ORS 414.705 to 414.750.

(4) Actions taken by providers, potential providers, contractors and bidders in specific accordance with ORS 414.705 to 414.750 in forming consortiums or in otherwise entering into contracts to provide health care services shall be performed pursuant to state supervision and shall be considered to be conducted at the direction of this state, shall be considered to be lawful trade practices

and may not be considered to be the transaction of insurance for purposes of the Insurance Code.

(5) Health care providers contracting to provide services under ORS 414.705 to 414.750 shall advise a patient of any service, treatment or test that is medically necessary but not covered under the contract if an ordinarily careful practitioner in the same or similar community would do so under the same or similar circumstances.

(6) A prepaid managed care health services organization shall provide information on contacting available providers to an enrollee in writing within 30 days of assignment to the health services organization.

(7) Each prepaid managed care health services organization shall provide upon the request of an enrollee or prospective enrollee annual summaries of the organization's aggregate data regarding:

(a) Grievances and appeals; and

(b) Availability and accessibility of services provided to enrollees.

(8) A prepaid managed care health services organization may not limit enrollment in a designated area based on the zip code of an enrollee or prospective enrollee.

(9)(a) A prepaid managed care health services organization shall reimburse a qualified community health center or safety net clinic for covered services provided by the center or clinic to an enrollee of the organization participating in the Healthy Kids Plan established under section 2 of this 2009 Act. The department by rule shall adopt standards for qualifying community health centers and safety net clinics to receive reimbursement under this subsection.

(b) As used in this subsection, "community health center or safety net clinic" means a nonprofit medical clinic or school-based health center that provides primary physical health, vision, dental or mental health services to low-income patients without charge or using a sliding fee scale based on the income of the patient.

SECTION 7. ORS 414.839 is amended to read:

414.839. (1) Subject to funds available, the Department of Human Services may provide public subsidies for the purchase of health insurance coverage provided by public programs or private insurance, including but not limited to the Family Health Insurance Assistance Program, for currently uninsured individuals [*based on incomes up to 200*] **whose incomes are at or below 200** percent of the federal poverty [*level*] **guidelines and currently uninsured children whose family incomes are at or below 300 percent of the federal poverty guidelines**. The objective is to create a transition from dependence on public programs to privately financed health insurance.

(2) Public subsidies shall apply only to health benefit plans that meet or exceed the basic benchmark health benefit plan or plans established under ORS 735.733.

(3) Cost sharing shall be permitted and structured in such a manner to encourage appropriate use of preventive care and avoidance of unnecessary services.

(4) Cost sharing shall be based on an individual's ability to pay and may not exceed the cost of purchasing a plan.

(5) The state may pay a portion of the cost of the subsidy, based on the individual's income and other resources.

SECTION 8. (1) The Department of Human Services is responsible for statewide outreach and marketing related to the Healthy Kids Plan established under section 2 of this 2009 Act in coordination with the Office of Private Health Partnerships.

(2) In addition to the duties described in subsection (1) of this section, to maximize the enrollment and retention of eligible children in the Healthy Kids Plan, the department shall

develop and administer a grant program to provide funding to organizations and local groups for outreach and enrollment activities.

(3) The department shall develop and administer an application assistance program to pay fees to entities that assist individuals with the application process, resulting in successful eligibility and enrollment outcomes, as determined by the department.

(4) The criteria to award grants and pay fees under subsections (2) and (3) of this section shall include, but are not limited to, the extent to which a grantee or entity:

(a) Provides information and assistance within diverse geographic areas or to culturally diverse communities in this state, including communities that need the information and assistance provided in alternative formats and languages other than English;

(b) Provides assistance with the application process;

(c) Provides assistance to individuals and families in enrolling and maintaining enrollment in the Healthy Kids Plan; and

(d) Is successful in enrolling children in the Healthy Kids Plan.

SECTION 9. As used in sections 10, 11 and 12 of this 2009 Act:

(1) "Carrier" has the meaning given that term in ORS 735.700.

(2) "Child" means a person under 19 years of age.

(3) "Health benefit plan" has the meaning given that term in ORS 735.720.

SECTION 10. (1) The Office of Private Health Partnerships shall administer a private health option to expand private health care coverage for Oregon's children.

(2) The office shall contract with carriers to provide health benefit plans approved under section 11 of this 2009 Act. The office shall manage the collection and the payment of premiums for children participating in the plans.

(3) A child whose family income is more than 200 percent but not more than 300 percent of the federal poverty guidelines qualifies for a subsidy to enable the child to enroll in:

(a) A health benefit plan offered through the private health option under subsection (2) of this section; or

(b) An employer-sponsored health benefit plan that is available to the child and that meets or exceeds the requirements for a basic benchmark health benefit plan under ORS 735.733.

(4) The office shall adopt rules for determining the subsidies to be paid under this section based upon the following factors:

(a) The income of the child's family;

(b) Family size; and

(c) Other factors established by the office.

(5) The office shall adopt rules under which families whose incomes are more than 300 percent of the federal poverty guidelines may purchase for their children health benefit plans offered through the private health option.

SECTION 11. (1) The Office of Private Health Partnerships must approve health benefit plans before they may be offered through the private health option described in section 10 (3)(a) of this 2009 Act. To be approved, health benefit plans must offer benefit packages comparable to those provided under section 2 (1)(a) of this 2009 Act and must cover mental health, vision and dental services.

(2) Approved health benefit plans may impose copayments or co-insurance amounts that are based upon a family's ability to pay as determined according to criteria adopted by the

office by rule.

(3) Approved health benefit plans may not exclude coverage of pre-existing conditions.

SECTION 12. Notwithstanding eligibility criteria and subsidy amounts determined pursuant to section 10 of this 2009 Act, the Office of Private Health Partnerships shall provide subsidies under the private health option to eligible children to the extent the Legislative Assembly appropriates funds for that purpose or establishes expenditure limitations to provide such subsidies.

SECTION 13. The Office for Oregon Health Policy and Research shall analyze and evaluate the implementation of the Healthy Kids Plan established under section 2 of this 2009 Act and report its findings to the Legislative Assembly every two years in the manner provided by ORS 192.245. The report must include at least the following information for the preceding two-year period:

(1) An estimate of the number of children who are eligible for but not enrolled in the plan;

(2) The number of children enrolled in the plan;

(3) The number of children disenrolled from the plan and the reasons for disenrollment;

(4) A description of any identified barriers to enrolling or maintaining enrollment of children in the plan and a description of the strategies developed by the office and the Department of Human Services to overcome the barriers;

(5) An estimate of the number of families who have voluntarily discontinued employer-sponsored dependent health coverage and enrolled their children in the plan; and

(6) The results of a survey conducted by or contracted for by the office that assesses the accessibility of health care for individuals under 19 years of age, the experience of such individuals with their health care and the health status of such individuals.

SECTION 14. There is established in the State Treasury, separate and distinct from the General Fund, the Private Health Option Program Account, which consists of moneys appropriated to the account by the Legislative Assembly and all moneys transferred as reimbursements to the account by the Department of Human Services under section 17 of this 2009 Act. Interest earned by the Private Health Option Program Account shall be credited to the account. All moneys in the Private Health Option Program Account are continuously appropriated to the Office of Private Health Partnerships to carry out the provisions of sections 10, 11 and 12 of this 2009 Act.

SECTION 15. (1) Except as otherwise provided in this section and ORS 735.710, the Office of Private Health Partnerships and the Department of Human Services may not disclose information provided as part of an application for enrollment in the Healthy Kids Plan established under section 2 of this 2009 Act except for purposes directly connected with the administration of the plan.

(2) The office and the department may exchange applicant information with other state and federal agencies for the purposes of determining eligibility for and administering the Healthy Kids Plan, identifying economic trends relevant to administration of the plan and providing the report required by section 13 of this 2009 Act.

(3) In accordance with applicable state and federal law, the office or the department may request that applicants provide their Social Security numbers and may use those numbers in the administration of the Healthy Kids Plan.

SECTION 16. (1) The Department of Human Services shall apply to the Centers for

Medicare and Medicaid Services for any approval necessary to obtain federal financial participation for implementing sections 2, 3, 10 and 11 of this 2009 Act, the amendments to section 3 of this 2009 Act by section 4 of this 2009 Act and the amendments to ORS 414.725 and 414.839 by sections 6 and 7 of this 2009 Act.

(2) The department shall adopt rules implementing sections 2 and 3 of this 2009 Act as soon as practicable after receipt of the necessary federal approval. The Office of Private Health Partnerships shall adopt rules implementing sections 9, 10, 11 and 12 of this 2009 Act as soon as practicable after receipt of the necessary federal approval.

SECTION 17. (1) The Healthy Kids Plan Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Healthy Kids Plan Fund shall be credited to the fund.

(2) Moneys in the Healthy Kids Plan Fund are continuously appropriated to the Department of Human Services for purposes of the Healthy Kids Plan established under section 2 of this 2009 Act.

(3) Notwithstanding subsection (2) of this section, if and to the extent that the Legislative Assembly determines that the Healthy Kids Plan is fully funded, moneys in the Healthy Kids Plan Fund established by this section may be used, in amounts determined by the Legislative Assembly, to fund other health services provided by the department with funds from Titles XIX and XXI of the Social Security Act.

(4) The department shall develop a system for reimbursement by the department to the Office of Private Health Partnerships for costs associated with administering the private health option of the Healthy Kids Plan.

SECTION 18. ORS 735.701 is amended to read:

735.701. (1) The Office of Private Health Partnerships is established.

(2) The office shall carry out the duties described under ORS 414.831, 735.700 to 735.714 and 735.720 to 735.740 **and sections 2, 3, 8, 9, 10, 11, 12 and 15 of this 2009 Act**.

SECTION 19. ORS 735.710 is amended to read:

735.710. (1) In carrying out its duties under ORS 735.700 to 735.714 and 735.720 to 735.740 **and sections 2, 3, 8, 9, 10, 11, 12 and 15 of this 2009 Act**, the Office of Private Health Partnerships shall:

(a) Enter into contracts for administration of ORS 735.700 to 735.714 and 735.720 to 735.740 **and sections 2, 3, 8, 9, 10, 11, 12 and 15 of this 2009 Act**, including collection of premiums and paying carriers.

(b) Retain consultants and employ staff.

(c) Enter into contracts with carriers or health care providers for health benefit plans, including contracts where final payment may be reduced if usage is below a level fixed in the contract.

(d) Set premium rates for eligible employees and small employers.

(e) Perform other duties to provide low-cost health benefit plans of types likely to be purchased by small employers.

(f) Establish contributions to be paid by small employers toward the premiums incurred on behalf of covered eligible employees.

(g) Establish procedures by rule for the publication or release of aggregate data relating to:

(A) Applicants for enrollment and persons enrolled in the Family Health Insurance Assistance Program;

(B) Health benefit plans for small employers offered by the office; and

(C) Other programs operated by the office.

(2) Notwithstanding any other health benefit plan contracted for and offered by the office, the office shall contract for a health benefit plan or plans best designed to meet the needs and provide for the welfare of eligible employees and small employers.

(3) The office may approve more than one carrier for each type of plan contracted for and offered, but the number of carriers shall be held to a number consistent with adequate service to eligible employees and family members.

(4) Where appropriate for a contracted and offered health benefit plan, the office shall provide options under which an eligible employee may arrange coverage for family members of the employee.

(5) In developing any health benefit plan, the office may provide an option of additional coverage for eligible employees and family members at an additional cost or premium.

(6) Transfer of enrollment from one health benefit plan to another shall be open to all eligible employees and family members under rules adopted by the office.

(7) If the office requests less health care service or benefit than is otherwise required by state law, a carrier is not required to offer such service or benefit.

(8) Health benefit plans for small employers contracted for and offered by the office must provide a sufficient level of benefits to be eligible for a subsidy under ORS 735.724.

(9) The office may employ whatever means are reasonably necessary to carry out the purposes of ORS 735.700 to 735.714 and 735.720 to 735.740 **and sections 2, 3, 8, 9, 10, 11, 12 and 15 of this 2009 Act**. Such authority includes but is not limited to authority to seek clarification, amendment, modification, suspension or termination of any agreement or contract that in the office's judgment requires such action.

SECTION 20. Sections 1, 8, 13 and 15 of this 2009 Act become operative on July 1, 2009.

SECTION 21. Sections 2, 3, 9, 11 and 12 of this 2009 Act and the amendments to ORS 414.025, 414.725, 735.701 and 735.710 by sections 5, 6, 18 and 19 of this 2009 Act become operative on the later of October 1, 2009, or the date the Department of Human Services receives any federal approval required to secure federal financial participation under section 16 of this 2009 Act.

SECTION 22. Section 10 of this 2009 Act, the amendments to section 3 of this 2009 Act by section 4 of this 2009 Act and the amendments to ORS 414.839 by section 7 of this 2009 Act become operative on the later of January 1, 2010, or the date the Department of Human Services receives any federal approval required to secure federal financial participation under section 16 of this 2009 Act.

SECTION 23. The Department of Human Services shall notify the Legislative Counsel upon receipt of approval or denial of any federal authorization necessary to implement the Healthy Kids Plan established under section 2 of this 2009 Act with federal financial participation.

SECTION 24. This 2009 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2009 Act takes effect on its passage.